Adopted October 28, 1997 by the Managed Health Care Improvement Task Force

MINIMIZING RISK AVOIDANCE STRATEGIES
FINDINGS AND RECOMMENDATIONS

I. FINDINGS

Fixed periodic per capita, or "capitated" payments by purchasers to health plans[1] and health plans to providers (i.e., medical groups, hospitals and other providers), if not adjusted for the medical needs of different patients, gives health plans and providers an incentive to avoid enrolling and developing expertise to care for the sickest patients.

These incentives result in "adverse selection", i.e., a competitive disadvantage for academic medical centers and other providers with reputations for excellence that attract the sickest patients. Moreover, the lack of risk adjustment attenuates price competition among health plans, as plans receiving unfavorable selection are not able to compete with plans getting favorable selection on a level playing field.

Currently, health plans may use stop loss coverage, carve outs, global case rates, and other mechanisms to protect providers from financial exposure to high cost cases. In addition, what is needed to combat the problem of adverse selection is diagnosis-based "risk adjustment", i.e., to adjust capitation payments to compensate health plans and providers for enrolling and caring for patients with more costly medical conditions, enough to eliminate incentives for skimming. According to Cardinal Bernardin, Archbishop of Chicago, "If we do not, we will witness a morally repugnant system in which plans will compete to avoid caring for the sick, thus avoiding a central purpose of healthcare altogether."[2]

A consensus has emerged among leading experts that good enough methods are now available and ought to be put into practice.[3] For a variety of important reasons, risk adjustment should begin to be implemented as soon as possible. Because of problems of data availability, it will take several years to complete implementation.

Risk adjustment suffers from a collective action problem. In order for risk adjustment to change the incentives of a large health plan, many firms, very large firms, or some large purchasing groups need to introduce it. One employer acting on its own can not correct the incentives of unadjusted capitation. Collective action by purchasers, including the state, is needed to influence this vitally important change.

In addition, to encourage health plans to contract with the best providers and to encourage providers to develop expertise in treating the sickest patients, the adjusted payments must be passed through the health plans to their contracting medical groups, hospitals and other providers. By leveling the playing field, risk adjustment can be expected to improve price competition among plans.

II. RECOMMENDATIONS

The California Managed Health Care Improvement Task Force recognizes that risk adjustment entails some extra cost and effort in the short run, and despite that, endorses risk adjustment as worth the additional investment. We base this recommendation on the reasoned analysis that in the long run, risk adjustment will save society resources by redirecting the incentives to providing more efficient, higher quality care for all patients.

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[1] Health insurance arrangements or health benefits financial intermediaries.

[2] Cardinal Bernardin, "Managing Managed Care", May 13, 1996.

[3] Newhouse J, et al, "Risk Adjustment and Medicare: Taking a Closer Look", *Health Affairs*, 16:5, September/October 1997, 26-43; and Luft H, expert testimony to the Managed Health Care Improvement Task Force, September 23, 1997.

Therefore, the Task Force recommends that California stimulate action to adopt risk adjustment while maintaining patient confidentiality, where technically feasible:

1. The Task Force recommends that the CalPERS Board of Administration be urged that CalPERS, preferably in combination with the University of California and PBGH, with its nearly three million members, take the lead in introducing risk adjustment to the California market. The Task Force recommends implementation of a state-of-the-art (i.e., to the degree they have significant predictive power, diagnosis, socio-economic, and other variables) risk adjustment system within three years. CalPERS should report to the Legislature in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why. The Task Force believes this would be in the best interests of California public employees, and would be a great public service to the people of California.

2. The California Department of Health Services (DHS) should be instructed to seek to join with the Health Care Financing Administration (HCFA, administrator of the Medicare and Medicaid programs) in a cooperative project with beneficiaries to explore expanded efforts to do risk adjustment for services to Medi-Cal beneficiaries. DHS should be required to report in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why.

3. Similarly, DHS should be instructed to participate in HCFA-sponsored risk adjustment demonstration projects for managed care plans serving Medicare beneficiaries as and when such demonstration projects are proposed.

4. The Task Force recommends that the state explore with the federal Office of Personnel Management a California pilot project for risk adjustment of premiums for health plans serving federal employees in California in the Federal Employees Health Benefits Program (FEHBP).

5. Upon implementation by CalPERS of a risk adjustment mechanism, requiring all purchasing groups to risk adjust payments to participating plans within a reasonable timeframe should be considered.

6. As soon as technically feasible, health plans should be required as a matter of licensure to risk adjust payments to their at-risk, contracting, treating providers in addition to using other mechanisms that appropriately compensate for risk (e.g., stop loss coverage, carve outs, global case rates); and when premiums are risk adjusted, to flow through those risk adjustments to the at-risk, treating provider as well.

7. Major purchasers, including the state, and foundations are strongly encouraged to make moving forward the science of risk adjustment (and the ability to monitor its impact on clinical outcomes for different populations) a high priority through funding and support.

8. The state entity for regulation of managed care[4] should be charged with overseeing these efforts and reporting on progress annually to the Legislature and Governor.

[4] The term "state entity for regulation of managed care" refers to the Department of Corporations or its successor.